

Client Intake Form

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Profession: _____ Age: _____

Physician's name: _____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or symptom, massage/bodywork may be contraindicated.

Massage Experience

1. Have you had a professional massage before?..... Yes No

2. What are your goals for treatment? _____

3. Have you received services for this problem before?..... Yes No

If yes, what _____

Current Health

4. Do you exercise regularly and/or participate in any sports?..... Yes No

If yes, which sports? _____

5. Have you recently suffered an injury?..... Yes No

If yes, describe: _____

6. Are you currently under the care of a physician?..... Yes No

If yes, explain: _____

7. Have you had recent surgery?..... Yes No

If yes, explain: _____

8. Have you experienced significant personal or professional change in the past 2 years? Yes No

9. Do you have any concerns for your physical or mental well-being?..... Yes No

10. Do you have any sensitivities to fragrances or oils?..... Yes No

If yes, explain: _____

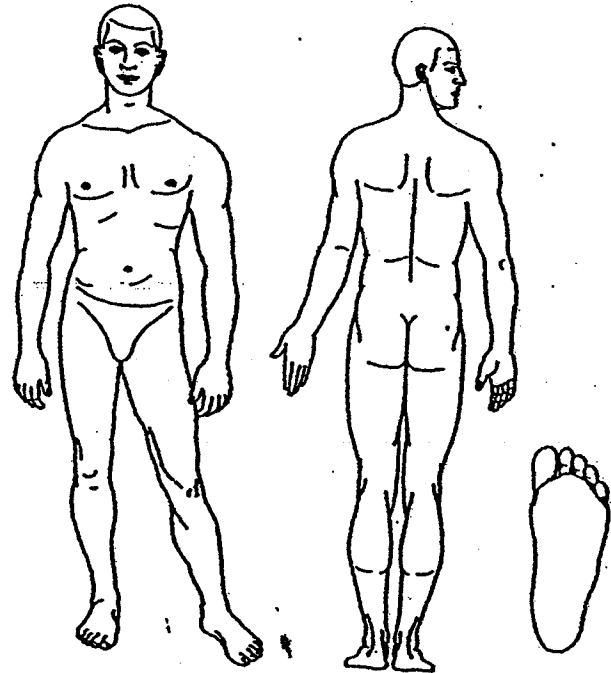
11. Do you have any foreign implants? IUD Screens Pace maker
 Metal implants Other

Describe: _____

HEALTH HISTORY (check one box per item)

	Yes/Current	Past	No
Dentures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thrombosis/Blood clot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back Pain/ Sciatica	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Broken bones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Varicose vein	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart/circulatory problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis or Joint Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nerve Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infectious Diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress Tension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please shade in areas of discomfort.



I understand that the massage therapy given here is for the purpose of stress reduction, relief from muscular discomfort, and for increasing blood, lymph and energy circulation. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand the massage therapist does not prescribe medical treatment or medication(s) and does not perform spinal manipulation. It has been made clear to me that massage therapy is not a substitute for medical examination or diagnosis. I have, to the best of my knowledge, stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

Client Signature _____ Date _____

Practitioner Signature _____ Date _____